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 synergenrx.com

SOLID ORGAN TRANSPLANT REFERRAL FORM (immunosuppression)

PATIENT INFORMATION (please attach insurance card)

Name:		<input type="checkbox"/> M	<input type="checkbox"/> F	DoB:	
Street:		City:		State:	Zip:
Phone:	Phone:	Allergies:			

CLINICAL INFORMATION (please attach clinical notes and labs)

Diagnosis with ICD-10 code

<input type="checkbox"/> B25.9 cytomegalovirus (CMV) prophylaxis and/or treatment	<input type="checkbox"/> Z94.0 kidney replaced by transplant	<input type="checkbox"/> Other: _____
<input type="checkbox"/> B44.9 <i>Aspergillus</i> prophylaxis and/or treatment	<input type="checkbox"/> Z94.2 lung replaced by transplant	<input type="checkbox"/> Other: _____
<input type="checkbox"/> B59 Pneumocystis PNA (PCP/PJP) prophylaxis and/or treatment	<input type="checkbox"/> Z94.3 heart replaced by transplant	<input type="checkbox"/> Other: _____
	<input type="checkbox"/> Z94.4 liver replaced by transplant	<input type="checkbox"/> Other: _____

Date of transplant:	Labs (please attach most recent results): <input type="checkbox"/> CMP <input type="checkbox"/> CMV level <input type="checkbox"/> C&S report(s)
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Current medication(s) with date(s) started: _____
 Prior medication(s) with date(s) of use: _____

PRESCRIPTION DAW (deliver to patient office)

Medication	Dose/Strength	Directions/Sig	Quantity	Refills
<input type="checkbox"/> transplant bag	Check here for BP monitor, thermometer, sunscreen, lip balm, pill splitter, pill organizer, hand sanitizer, & masks			
Immunosuppression				
<input type="checkbox"/> azathioprine	Tabs: <input type="checkbox"/> 50mg <input type="checkbox"/> 75mg <input type="checkbox"/> 100mg			
<input type="checkbox"/> cyclosporine, modified (Gengraf, Neoral)	Caps: <input type="checkbox"/> 25mg <input type="checkbox"/> 50mg <input type="checkbox"/> 100mg Soln: <input type="checkbox"/> 100mg/mL			
<input type="checkbox"/> cyclosporine, non-modified (SandIMMUNE)	Caps: <input type="checkbox"/> 25mg <input type="checkbox"/> 50mg <input type="checkbox"/> 100mg Soln: <input type="checkbox"/> 100mg/mL			
<input type="checkbox"/> Envarsus	Tabs: <input type="checkbox"/> 1mg <input type="checkbox"/> 4mg			
<input type="checkbox"/> everolimus (Zortress)	Tabs: <input type="checkbox"/> 0.25mg <input type="checkbox"/> 0.5mg <input type="checkbox"/> 0.75mg <input type="checkbox"/> 1mg			
<input type="checkbox"/> mycophenolate mofetil (Cellcept)	Caps: <input type="checkbox"/> 250mg Tabs: <input type="checkbox"/> 500mg			
<input type="checkbox"/> mycophenolic acid (Myfortic)	Tabs: <input type="checkbox"/> 180mg <input type="checkbox"/> 360mg			
<input type="checkbox"/> prednisone	Tabs: <input type="checkbox"/> 1mg <input type="checkbox"/> 5mg <input type="checkbox"/> 10mg			
<input type="checkbox"/> sirolimus (Rapamune)	Tabs: <input type="checkbox"/> 0.5mg <input type="checkbox"/> 1mg <input type="checkbox"/> 2mg Soln: <input type="checkbox"/> 1mg/mL			
<input type="checkbox"/> tacrolimus (Prograf)	Caps: <input type="checkbox"/> 0.5mg <input type="checkbox"/> 1mg <input type="checkbox"/> 5mg			
Other:				

PRESCRIBER INFORMATION

Prescriber:		Supervising Physician:			
Contact Name:		Contact Method: <input type="checkbox"/> Phone <input type="checkbox"/> Fax <input type="checkbox"/> Email:			
Phone:		Ext:	Fax:		
Street:		City:		State:	Zip:
Signature:		Date:		NPI:	

*By signing this form, I authorize Synergen Rx LLC and its employees to act as authorized agents on behalf of my office to obtain prior authorization through my patient's insurance plan and to facilitate the enrollment of the patient into patient assistance programs with manufacturers and other foundations.

SOLID ORGAN TRANSPLANT REFERRAL FORM

(opportunistic infection prophylaxis and treatment)

PATIENT INFORMATION (please attach insurance card)

Name:		<input type="checkbox"/> M	<input type="checkbox"/> F	DoB:	
Street:		City:		State:	Zip:
Phone:	Phone:	Allergies:			

CLINICAL INFORMATION (please attach clinical notes and labs)

Diagnosis with ICD-10 code

- | | | |
|---|---|---------------------------------------|
| <input type="checkbox"/> B25.9 cytomegalovirus (CMV) prophylaxis and/or treatment | <input type="checkbox"/> Z94.0 kidney replaced by transplant | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> B44.9 <i>Aspergillus</i> prophylaxis and/or treatment | <input type="checkbox"/> Z94.2 lung replaced by transplant | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> B59 Pneumocystis PNA (PCP/PJP) prophylaxis and/or treatment | <input type="checkbox"/> Z94.3 heart replaced by transplant | <input type="checkbox"/> Other: _____ |
| | <input type="checkbox"/> Z94.4 liver replaced by transplant | <input type="checkbox"/> Other: _____ |

Date of transplant: _____ **Labs (please attach most recent results):** CMP CMV level C&S report(s)

Current medication(s) with date(s) started: _____
 Prior medication(s) with date(s) of use: _____

PRESCRIPTION

DAW (deliver to patient office)

Medication	Dose/Strength	Directions/Sig	Quantity	Refills
Prophylaxis and/or Treatment, <i>Aspergillus</i>				
<input type="checkbox"/> Cresemba	Caps: <input type="checkbox"/> 74.5mg <input type="checkbox"/> 186mg	<input type="checkbox"/> Initiation: 372mg PO Q8h x 6 doses <input type="checkbox"/> Maintenance: 372mg PO once daily		
<input type="checkbox"/> posaconazole	Susp: <input type="checkbox"/> 40mg/mL Tab: <input type="checkbox"/> 100mg			
<input type="checkbox"/> voriconazole	Susp: <input type="checkbox"/> 40mg/mL Tab: <input type="checkbox"/> 50mg <input type="checkbox"/> 200mg			
Prophylaxis and/or Treatment, CMV				
<input type="checkbox"/> Livtency	200mg tablet	400mg PO twice daily for _____ weeks		
<input type="checkbox"/> Prevymis	Tab: <input type="checkbox"/> 240mg <input type="checkbox"/> 480mg	_____mg PO once daily for _____ weeks		
<input type="checkbox"/> valacyclovir	Tab: <input type="checkbox"/> 500mg <input type="checkbox"/> 1g			
<input type="checkbox"/> valganciclovir (Valcyte)	Soln: <input type="checkbox"/> 50mg/mL Tab: <input type="checkbox"/> 450mg			
Prophylaxis and/or Treatment, PCP/PJP				
<input type="checkbox"/> atovaquone	750mg/5mL suspension	10mL (1.5g) PO once daily		
<input type="checkbox"/> SMZ/TMP	Susp: <input type="checkbox"/> 200/40mg per 5mL Tab: <input type="checkbox"/> 800/160mg <input type="checkbox"/> 400/80mg			
Other:				

PRESCRIBER INFORMATION

Prescriber:		Supervising Physician:			
Contact Name:		Contact Method: <input type="checkbox"/> Phone <input type="checkbox"/> Fax <input type="checkbox"/> Email:			
Phone:		Ext:	Fax:		
Street:		City:		State:	Zip:
Signature:		Date:		NPI:	

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